In accordance with the *Privacy Amendment (Private Sector) Act 2000*, you are entitled to access personal information about yourself held by this organisation. An administration fee applies to cover tasks associated with this service, eg. preparation and photocopying. Every endeavour will be made to process Requests for Information within *30 working days*. Your medical record contains sensitive personal information. Once in possession of this information, we recommend you take all appropriate measure to safeguard your privacy.

**Patient name**: **Date:**

**Address :**  **Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number/ Mobile Number: **Date of Birth**:

|  |  |
| --- | --- |
| **Service Requested (please tick the appropriate box)**  | **Cost of Service**  |
| I would like information from my medical record ( Please indicate ): \_\_\_ **Health Summary only**  \_\_\_ **Copy of complete patient file on USB - Patient to collect**  | no charge$40.00 (individual ) $65.00 (Family) Plus $15.00 postage (registered) |
| **TOTAL COST OF SERVICE**  | $ |

**We request that patients collect documents from the practice, for privacy protection reasons, we do not have a policy of posting documents unless in extenuating circumstances.**

**ACKNOWLEGEMENT OF RECEIPT**

I hereby acknowledge I have requested access to the personal information in my medical record.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL FAMILY MEMBERS:**

**If completing for family members: please have each family member complete full name, DOB, and signature. Children 17 years and under, parent or carer can sign on their behalf.**

* **Patient name**: **Date of Birth**: **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Patient name**: **Date of Birth**: **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Patient name**:  **Date of Birth**: **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Patient name**:  **Date of Birth**: **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office use only:**

Patient Photo ID sighted by Staff: **YES/NO** Patient made aware of cost **YES / NO**